for established left ventricular failure or given in the late afternoon to prevent paroxysmal nocturnal dyspnoea. The need for potassium supplements is governed by many factors, such as the potassium content of the diet, the presence or absence of primary or more commonly secondary hyperaldosteronism. It must be remembered that severe sodium restriction is a powerful stimulant to aldosterone secretion; therefore, if dietary sodium is restricted, potassium supplements are likely to be needed.

Finally, Dr. Susan Cotton and I[1] did not report occasional evidence of mild liver dysfunction in patients treated with guanoxan, but five cases of frank hepatitis with jaundice, one of them fatal, in addition to laboratory evidence suggestive of hepatic dysfunction in a third of the first 100 treated patients.—I am, etc.,

E. MONTUSCHI.

Whittington Hospital,
London N.19.

REFERENCE

1 Cotton, S. G., Lovel, T. W. I., and Montuschi, E., *Clinical Trials Journal*, 1967, **4**, 707.

SIR,—The first article on hypotensive drugs, Today's Drugs (10 May, p. 365) will be of considerable value in guiding practitioners in the prescribing of drugs for the treatment of hypertension. It is unfortunate, therefore, that an error has crept into the Table indicating the daily doses of some of the more commonly used hypotensive agents. The dose of chlorthalidone (Hygroton, Geigy), is given as 100–200 mg. per day. This dose grossly exceeds that which is recommended—namely, 50 mg. per day. There is evidence[1] that little benefit is to be obtained in the use of a larger dose than 50 mg. daily in the maintenance of the majority of hypertensive patients.—I am, etc.,

J. DOMENET,
Medical Department,
Geigy Ltd., Pharmaceuticals Division.
Macclesfield, Ches.

REFERENCE

1 Cranston, W. I., *et al.*, *Lancet*, 1963, **2**, 966.

** We have shown Dr. Domenet's letter to our contributor who replies: "The daily dose of 100–200 mg. of chlorthalidone was based on a majority opinion taken from the literature. The observations of Cranston and his colleagues, cited by Dr. Domenet, were that 50 mg. daily produced a mean blood pressure fall of 17·9/8·9 (systolic/diastolic) mm. Hg, 100 mg. daily produced a mean fall of 27·5/13·9, and 200 mg. daily a fall of 29·8/14·7. The wide range of variation of individual patients and the relatively small numbers in the trial make statistics scarcely applicable, but the general trend of the results was the same for chlorthalidone as for the two thiazides tested. Most trials of chlorthalidone in hypertension have used daily doses between 100–200 mg. daily, but if one desires a slightly smaller hypotensive effect with a corresponding reduction in cost and possible complications of therapy then it is very reasonable to use 50 mg. daily, which certainly has a measurable and significant hypotensive effect, even though it is only about two-thirds of that achieved with 100 mg.

"Dr. Domenet, however, does us a useful service in emphasizing the way in which the dose/response curves for diuretics in the treatment of hypertension tend to become relatively flat in the higher dose range, so it may well be correct that there is little virtue in giving the full dose of 200 mg. of chlorthalidone or 10 mg. daily of bendrofluazide when nearly as good blood pressure reduction can be achieved with considerably smaller doses."—ED., *B.M.J.*

Miliary Tuberculosis

SIR,—In the article on miliary tuberculosis in adults (3 May, p. 273), the difficulty was stressed of making the diagnosis in elderly patients. This is also the case in young children. Bentley, Grzybowski, and Benjamin[1] showed there had been a failure to diagnose the condition radiologically in nine out of 28 children found to have miliary tuberculosis at post mortem. Occult or cryptic miliary tuberculosis can present considerable diagnostic difficulty in small children with tuberculosis complicating kwashiorkor. A high index of suspicion for the condition should be kept by those working in a famine area.—I am, etc.,

J. M. WEDDELL.

Medical Research Council,
Epidemiological Research Unit
(South Wales),
Cardiff.

REFERENCE

1 Bentley, F. J., Grzybowski, S., and Benjamin, B., *Tuberculosis in Childhood and Adolescence*, 1954. London, National Association for the Prevention of Tuberculosis.

Metabolic Response in Ethnic Groups

SIR,—May we reply briefly to Dr. D. Craddock's criticism (26 April, p. 247) of our paper (22 March, p. 748)?

First-cousin marriages are very common among Moslem Indians in Johannesburg, occurring in about 60% of unions in one study,[1] and it is reasonable to postulate that genetic factors play some role in their metabolic responses, including the fact that they suffer from diabetes mellitus more frequently than do whites.

We have no wish to get involved in the "sugar controversy," but we must point out that sucrose is not absent from the diet of Johannesburg Africans. There are no accurate figures on the sugar consumption of these people, but there is no doubt that their intake of sucrose, both as such and in the form of jams, cold drinks, confectionery, etc., is substantial.

Our subjects were matched in respect of their physical characteristics, and at the same time were representative of their respective population groups, which explains why the whites were taller and heavier than the Africans. However, as indicated in our paper, when the weights were expressed as percentages of ideal body weight there was no significant difference between the groups.—We are, etc.,

H. C. SEFTEL.
A. H. RUBENSTEIN.

Department of Medicine,
University of the Witwatersrand
Medical School,
S. Africa.

REFERENCE

1 Seftel, H. C., *Medical Proceedings*, 1967, **13**, 3.

Treatment of the Phobic Anxiety State

SIR,—I refer to the article "Anxiety Neuroses and Phobic States. II—Diagnosis and Management" by Professor Martin Roth and Dr. D. H. Myers (1 March, p. 559). There is clearly a difference of opinion between these authors and Dr. William Sargant (5 April, p. 49).

Professor Roth and Dr. Myers state "dangerous interaction may occur between a M.A.O.I. and any of the following drugs: the opiates, pethidine, local anaesthetics, sympathomimetic amines, methyldopa, and the tricyclic antidepressants. M.A.O.I.s are inactivated slowly: for this reason these foods and drugs must be avoided both during treatment and for 14 days afterwards."

Dr. Sargant, on the other hand, specifically uses tricyclic antidepressants to establish a normal sleep pattern. "If the patient's sleep is impaired, specially by early morning waking, then we consider that monoamine-oxidase inhibitor drugs should be given during the day and a tricyclic antidepressant should also be given in the evening to try and get a return to normal sleep pattern."

When one specialist in psychological medicine advocates a method of treatment which is stated to be frankly dangerous by another, could a non-specialist like myself kindly ask for clarification?—I am, etc.,

GEORGE C. WILSON.

Kogarah Bay,
N.S.W., Australia.

Bilateral Posterior Dislocation of Shoulders

SIR,—In view of the low incidence of posterior dislocation of the shoulder, compared with that of anterior dislocation, it would seem justified to report an interesting case of bilateral posterior dislocation which recently presented in the accident room of this hospital.

The patient was a woman of 68 years who was otherwise healthy and gave no history of previous dislocation of the shoulder. She had been cleaning her electric fire the previous evening without having first taken the precaution of switching it off. While doing so she rested her left hand on the fire frame and then accidentally touched the element with her right hand. The shock she received made her fall backwards against her bed, and subsequently she found that she could move neither arm. She remained like this during the night, apparently in surprisingly little pain, before attending the infirmary the following afternoon.

On examination there was obvious deformity of both shoulders, and both arms were held immobile by her sides—a posture that would be instantly recognizable again. The only other physical signs were almost complete inability to move either shoulder and a small patch of erythema on her right hand, which was the site of contact with the hot element. She otherwise appeared healthy.

Radiographs subsequently demonstrated the presence of bilateral posterior dislocation of the shoulder, and she made a good recovery following reduction. The mechanism of dislocation here was presumably spasm of the posterior shoulder girdle muscles forcibly pulling the humeral heads posteriorly, owing to the electric current passing across the body from one arm to the other as one hand was